HIPAA Consent

I understand that as part of my healthcare, Gastro Florida originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future treatment. I understand that this information serves as:

- A basis for planning my care and treatment
- A means for communication among health professionals who contribute to my care, such as referrals
- A source of information for applying my diagnosis and treatment information to my bill
- A means by which a third-party payer can verify that services billed were actually rendered
- A tool for routine healthcare operations, such as assessing quality and reviewing the competence of staff.

Please Print

Restrictions

I request the following restrictions to the use or disclosure of my health information:

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Please tell us with whom we may discuss your protected health information:
(Example: spouse (name), children (name(s)), other relatives (name(s), friends or caregivers (name(s))

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Messages or Appointment Reminders

May we leave a message at your home using doctor's/practice name: ☐ Yes ☐ No

May we leave a message at your work using doctor's/practice name: ☐ Yes ☐ No

I understand that as part of treatment, payment, or healthcare operations, it may become necessary to disclose health information to another entity, i.e. referrals to other healthcare providers. I consent to such disclosure for these uses as permitted by law. I fully understand and ☐ accept ☐ decline this consent.

Notice of Privacy Practices

I acknowledge that I have been informed of Gastro Florida's Notice of Privacy Practices that provides a description of Protected Health Information use and disclosures. I understand that I have the right to review the Notice of Privacy Practices prior to signing this statement. I understand that the Gastro Florida reserves the right to change its Notice of Privacy Practices that will be effective for health information Gastro Florida already has about me, as well as any they receive in the future. Gastro Florida will post a current copy of the Notice. I understand that I may obtain a copy of the current Notice in effect upon request. I have read all of the above and understand/agree to all the provisions therein regarding responsibility for payment, permission for treatment and Notice of Privacy Practices.

________________________________ ________________________________

Patient/ Guardian Signature Date

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Printed Name of Person Signing Consent Form

If other than the patient (Patient Name)________________________ is signing, are you the legal guardian, custodian or have Power of Attorney for this patient, for treatment, payment or healthcare operations? ☐ Yes ☐ No